

**Massachusetts Rehabilitation Commission
Statewide Employment Services Department
Individual Members Planning and Assessing Choices Together
Project IMPACT
1-800-734-7475
Fax (617) 204-3847**

INTAKE REFERRAL FORM

Benefits Specialist: _____

Date: _____

Referral Source Name: _____

Description of Service: _____

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CLIENT INFORMATION

Receiving: ☐ SSI \$ _____ ☐ SSDI \$ _____

☐ VA Pension \$ _____ Compensation \$ _____

☐ Transition

Name: _____ D.O.B. _____

Address: _____

City: _____ ZIP _____

Phone: _____ Email: _____

SSN# _____ Rep Payee _____

Is Client Working? _____ YES _____ NO Start Date: _____

Employer Information: _____

Additional Information: _____

